Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 21, 2024

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: November 22, 2023

Dear Administrator:

On January 31, 2024, we notified you a remedy was imposed. On February 12, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 10, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 22, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 31, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 22, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 10, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 21, 2024

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

Re: Reinspection Results
Event ID: DYZF12

Dear Administrator:

On January 22, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 22, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01** B. WING _____	R **01/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 761} SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 761}	K761 – Maintenance, Inspection & Testing Doors • Inspection – Latch and Gap has been scheduled annually in TELS software system for January 2024. • The inspection will be scheduled or completed by February 10th, 2024, by the maintenance manager or technician. • Completion date: February 10th, 2024	2/10/24
{K 901} SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories	{K 901}		2/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01** B. WING _____	R **01/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 901}	Continued From page 1 Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 901}	K901 – Building System Categories • Risk Assessment will be completed by February 10th, 2024	
{K 914} SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated	{K 914}		2/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01** B. WING _____	R **01/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 914}	Continued From page 2 repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 914}	K914 – Electrical Systems – maintenance and testing • The electrical receptacle testing document is being reconfigured and developed with complete details of date and room numbers. • The maintenance manager and technician will be trained in necessary complete documentation. • Date Completed: February 10th, 2024.	
{K 918} SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	{K 918}		2/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01** B. WING _____	R **01/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 918}	Continued From page 3 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 918}	K918 – Electrical Systems – Essential Electric System Maintenance and Testing • Weekly Generator Inspection has been added to the Weekly Maintenance Rounding Checklist • The monthly generator run – transfer load – inspection is in the TELS software system. • The 4-hour generator test will be completed by January 10th, 2024. • The report will be filed in the maintenance book for completion. • Date Completed: February 10th, 2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2023

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: November 22, 2023

Dear Administrator:

On November 22, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 22, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 22, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/20/23- 11/22/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101	E 041		1/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems,	E 041	The facility has initiated a Weekly Maintenance Rounding Checklist that includes the weekly generator inspection. The checklist will be turned into the administrator weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 3 sections 8.4.1, 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.1. This had the potential to affect all residents, staff, and visitors within the facility. Findings include: During observation and interview on 11/21/2023 between 8:45 a.m., and 11:45 a.m., the administrator confirmed the facility lacked evidence of completed weekly generator inspections during the weeks of 11/3/23, 11/13/23, and prior to 3/2023, In addition, they verified the monthly emergency generator inspection report for 1/2023 lacked evidence of completion, and they were unable to provide documentation showing that the generator has had a four (4) hour load bank test completed within the last 36 months.	E 041	The monthly generator sheets have been updated with current information including dates and details of the generator. The monthly generator inspections with a 30 minutes load transfer have been added to the TELS software system that is the scheduled maintenance for the maintenance team. The administrator gets a weekly emailed report of items are completed or not. The 4 hour load transfer is scheduled for January 24th, 2024. The maintenance team will be educated on expectations December 19th, 2023. Completion Date: January 3rd, 2024	
F 000	INITIAL COMMENTS On 11/20/23-11/22/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54217148C (MN00098224). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess residents for the ability to self administer medications for 1 of 1 resident (R2) reviewed for medications at bedside. Findings include: R2's quarterly Minimum Data Set (MDS) dated 8/15/23, indicated R2 had intact cognition and diagnoses of congestive heart failure, chronic kidney disease, and type II diabetes. R2 required extensive assistance with bed mobility, locomotion off the unit, and toileting, limited assistance with transfers and dressing, and supervision with locomotion on the unit. R2's physician's orders included orders for the following medications: 1. Albuterol Sulfate Aerosol Solution, inhale 2 puffs orally four times a day for shortness of breath. 2. Nystatin external powder 100000 unit/gram, apply to vulva topically two times a day for yeast active 9/22/2023	F 554	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. It is the facility's intent residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. • R2's medications were removed from the bedside until a Self-Administration of Medication (SAM) Evaluation was conducted and found the resident to be safe to administer her Albuterol Inhaler, Flonase Nasal Spray and Systane eye drops. Interdisciplinary Team (IDT) supported the resident's evaluation and Provider was notified of her ability to self-administer medication. Physician orders were obtained accordingly. • Residents who request self–administer medication have the	1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 5 3. Nystatin Powder , apply to groin topically two times a day for yeast until resolved active 5/25/2021 4. Biofreeze external gel 4 %, apply to neck and shoulders topically two times a day for pain active 3/14/2023 5. Artificial tears ophthalmic solution 1.4 %, instill 1 drop in both eyes three times a day for dry eyes active 8/18/2023. It further lacked a doctor's order for R2 to be able to administer her own medciations. R2's self administration of medication assessment (SAM) dated 11/9/23, indicated R2 was not capable of administering or storing medications. During observation and interview on 11/20/23 at 12:39 p.m., R2 was laying in bed and the following medications were on her bedside table next to her: albuterol aerosol inhaler, nystatin topical powder, thera tears (over the counter eye drops), bio freeze external gel 4%, and fluticasone propionate (nasal spray) 50 mcg in which R2 did not have a physician's order for. R2 stated the nurses were aware she had the medications in her room and they've never said anything about it. During observation and interview on 11/20/23 at 12:50 p.m., registered nurse (RN)-A verified the medications (above) were on the bedside table in R2's room and stated wasn't sure if R2 had been assessed to self administer them. RN-A then looked up R2's most recent SAM in point click care (computer system) and noted it indicated R2 wasn't capable of self administering or storing medication and stated "Oh, I know that's really bad."	F 554	potential to be affected. All current residents were asked if they would like to Self-Administer medications and evaluated per the facility's policy. All residents wishing to self-administer will be evaluated upon admission and on a quarterly basis based on the MDS schedule. • Self-Administration of Medication Policy and procedure will be reviewed and revised as necessary by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Education on self-administration of medications and keeping medications at the bedside provided to clinical staff by 12/22/2023. • Education to the licensed nurses on the SAM evaluation and to refrain from leaving medications at the bedside unless the resident has been approved to self-administer medications by the provider and the IDT will be completed by 12/22/23. All self-administer medications will be stored appropriately in a lock box at the bedside or with the licensed nurse. • Director of Nursing and/or Designee will audit the storage of self-administered medications x3 days per week then weekly x3 weeks. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. The QAA/QAPI Committee will determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible Party: Director of Nursing and/or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 6 During interview on 11/21/23 at 8:30 a.m., licensed practical nurse (LPN)-A stated nurses were responsible to complete a SAM to evaluate whether or not a resident can administer their own medications. During interview on 11/21/23 at 8:43 a.m., registered nurse (RN)-B stated nures were responsible for assessing residents using a SAM before they're able to administer their own medications. During an interview on 11/21/23 at 12:59 p.m., nurse manager LPN-B verified R2 did not have a doctor's order to self administer medcations and the most recent SAM dated 11/9/23, indicated R2 was not capable of adminstering or storing her own medications and therefore should not have any medications in her room/at bedside. LPN-B also verified the risk of having medications at bedside could result in adverse reactions, overdose, and/or taken by the wrong route. During an interview on 11/22/23 at 9:12 a.m., the director of nursing (DON) stated residents need to be assessed using a SAM before they are able to administer their own medciations and if a resident hadn't been assessed or were assessed to not be able to self administer, they should not have medications at bedside. The DON further stated if a resident who wasn't assessed or assessed to not be capable of adminstering their own medication had medications at bedside would be at risk of taking too much/too little or too frequently. The facility's policy on medciation administration revised on 4/19 indicated residents may self	F 554	Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 7 administer their own medications only if the attending physician, in conjuntion with the interdisciplinary care planning team, has determined that they have the decision-making capability to do so safely.	F 554		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure effective collaboration between the facility and a contracted hospice organization which affected 1 of 1 resident (R13) reviewed for hospice services, and failed to ensure vascular wounds were assessed for 1 of 2 residents (R23) reviewed for wounds. Findings include: Hospice R13's quarterly Minimum Data Set (MDS) dated 9/6/23, indicated required extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene. Further, the MDS indicated in section O R13 received hospice services in the past 7 days.	F 684	Hospice: It is the policy of the facility that all residents at end of life receive hospice services, if elected. • R13's Comprehensive Care Plan was updated to reflect the Hospice Plan of Care. • All residents who receive hospice services have the potential to be affected by this practice. • All residents receiving hospice services care plans were updated with the type and frequency of visits provided by the 3rd party hospice agency. • Comprehensive Care Planning and Hospice Care Plan Policy and procedures will be reviewed by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023.	1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 Review of R13's significant change MDS date 6/9/23, indicated in section O R13 did not receive hospice services in the past 14 days. R13's Medical Diagnosis form indicated the following diagnoses: severe sepsis with septic shock (a life threatening complication of an infection), urinary tract infection, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (high blood pressure), and depression. R13's care plan dated printed 11/21/23 indicated R13 was at risk for falls and hospice was evaluating medications. The care plan lacked any other indication of hospice services. R13's hospice notice of election indicated R13 began hospice services on 6/8/23. R13's hospice binder included a hand written note dated 11/29/23 which indicated the nurse visited. The last hospice nursing assistant (NA) note indicated the hospice aide visited on 11/8/23. The binder indicated what the cares the hospice aide was to perform, but not what day the hospice aide would visit. Interview on 11/21/23 at 9:00 a.m., licensed practical nurse (LPN)-A indicated she did not know when the hospice aide was in the building or what the hospice aide assisted R13 with. Interview on 11/21/23 at 9:50 a.m., NA-C indicated she worked with R13 a couple times a week, and sees the hospice nurse once a week, but does not know when the hospice aide visits, or what the hospice aide helps R13 with when	F 684	• Education to clinical staff was provided on collaboration of care with Hospice Providers by 12/22/2023. • Hospice provider to update Hospice Communication Binder(s) and a verbal report on each visit to a Care Center staff member. • Policy and procedure(s) will be reviewed and revised by as necessary by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Director of Nursing and/or Designee will conduct audits on all residents admitted to and receiving hospice services on a weekly basis x6 weeks. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. The QAA/QAPI Committee will determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible Party: Director of Nursing and/or Designee Date Certain: 01/03/2024 Skin/Wound Evaluations: It is the facility's intent to minimize the risk of complications related to pressure ulcers and identify skin alterations as soon as possible. • R23's skin inspection was completed on 12/05/23 by a licensed nurse. • Residents in the facility have the potential to be affected by this practice. All residents residing in the facility had a skin inspection on 12/05/23. • Pressure Ulcer Prevention and Identification Policy and procedure will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 they are here. Interview on 11/21/23 at 2:00 p.m., the director of nursing (DON) and LPN-B indicated the expectation would be for the care plan to include hospice and the care hospice was to provide, and verified R13's plan of care lacked the hospice information. Interview on 11/22/23 at 8:09 a.m., hospice nurse-A indicated communication regarding days of service should have been discussed on R13's admit to hospice. Hospice nurse-A indicated all hospice nursing assistants are to complete a shower or bed bath, and assist the resident with dressing, lotioning and any other personal care needed at the time, and the scheduled day was Wednesday. Review of the facility's care plan policy dated March 2022 directed the following: The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS (minimum data set) assessment (Admission , Annual or Significant change), and no more that 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being.	F 684	reviewed by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Education to clinical staff was provided timeliness of Skin Inspections every seven (7) days and as indicated by 12/22/23. A licensed nurse will complete a skin inspection every seven (7) days unless indicated sooner. Refusals will be documented in the electronic health record and the DON and provider will be notified. • Weekly Skin Audits to be completed by the Director of Nursing and/or Designee x5/week x3 weeks then weekly x3 weeks. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. The QAA/QAPI Committee will determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible Party: Director of Nursing and/or Designee Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10	F 684		

Wound Assessment

R23's quarterly Minimum Data Set (MDS) dated 10/13/23, indicated R23 was cognitively intact and had diagnoses of chronic venous insufficiency (poor blood flow) and bilateral lower extremity vascular wounds.

R23's skin Care Area Assessment (CAA) dated stated R23 was at risk of skin breakdown related to impaired mobility, fragile skin, and chronic lower extremity venous ulcers.

R23's care plan dated 11/13/23, indicated R23 had skin alterations of venous ulcers on bilateral lower extremities. Interventions included to observe for signs or symptoms of infection and follow skin assessments per protocol.

R23's provider order dated 9/8/22, directed staff to document a skin/wound assessment note every Thursday unless treated by the wound team.

R23's medical record lacked evidence R23's wounds had been assessed by nursing staff or the wound team since 10/19/23.

An observation on 11/21/23 at 8:26 a.m., licensed practical nurse (LPN)-B and nurse practitioner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 (NP)-A entered R23's room to provide wound care during weekly wound rounds. NP-A assessed and changed dressings for R23's lower extremity wounds. When interviewed on 11/21/23 at 8:45 a.m., NP-A stated R23 didn't always allow wound cares to be completed during wound rounds but allowed care today. NP-A further stated R23 was particular about what kind of wound treatment was allowed and stated the wounds are improving. Furthermore, NP-A wasn't sure if the wound practitioners usually document a progress note for refusal or not as they were filling in. When interviewed on 11/21/23 at 8:58 a.m., LPN-A verified R23 often refused treatments and cares from the wound team, but always allowed nursing to complete the dressing changes. LPN-A verified the order for a wound assessment. Further, LPN-A verified if R23 refused care from the wound team LPN-A was unable to find documentation of refusals or wound assessments since 10/2023. LPN-A was not sure why there was not any notes documented for R23's wounds. When interviewed on 11/21/23 at 2:22 p.m., LPN-B stated if wound monitoring was refused by residents a discussion would happen in interdisciplinary team meetings. LPN-B stated if a resident refused wound care by the wound team provider, a note should be placed, and nursing staff should complete the weekly assessment. LPN-B verified R23's medical record lacked any completed wound assessments by either the wound team or nursing since 10/2023.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 When interviewed on 11/22/23 at 10:20 a.m., the director of nursing (D0N) expected staff to document refusals of wound assessments and attempt later to complete the wound assessment. If the resident refused further, the provider should be notified. DON further stated a weekly assessment by a nurse was important to monitor the progression of the wound and note any decline or concerns of the wound. A facility policy titled Pressure Ulcer/Injury Risk Assessment revised July 2017, directed staff to document types of assessments conducted, the condition of the residents skin alteration (size, location, etc), any problems or complaints by the resident. If the resident refused assessment, the provider was to be notified.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a resident (R2) was assessed to safely use and store a curling iron for 1 of 1 resident reviewed for accidents. Findings include: R2's quarterly Minimum Data Set (MDS) dated	F 689	It is the policy of the facility that the resident environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. • R2’s curling iron was removed from the room. Occupational Therapy to	1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 8/15/23, indicated R2 had intact cognition and diagnoses of congestive heart failure, chronic kidney disease, and weakness. It further indicated R2 was independent with personal hygiene after staff set up the supplies. R2's care plan dated 11/15/23, indicated R2 had a self care performance deficit related to weakness with an intervention of assistance of one staff with personal hygiene. During observation on 11/20/23 at 12:39 p.m., R2 was laying in bed. Next to the bed (on the right side) there was an extension cord with four outlets and one of the outlets had a curling iron plugged into it and the curling iron was laying inside the second drawer of the nightstand. During observation and interview on 11/21/23 at 8:30 a.m., licensed practical nurse (LPN)-A verified R2 had a curling iron in the second drawer of her night stand and it was plugged into the extension cord next to her bed. LPN-A left R2's room and did not remove the curling iron or unplug it. During 11/22/23 8:45 a.m. R2 was laying in bed. Next to the bed (on the right side) there was an extension cord with four outlets and one of the outlets had a curling iron plugged into it and the curling iron was laying in side the second drawer of the nightstand. During an interview on 11/21/23 at 12:10 p.m., nursing assistant (NA)-B stated she had seen a curling iron plugged into an extension cord in R2's room. NA-B further stated the curling iron was kept inside a drawer in R2's nightstand.	F 689	evaluate resident for safety with using and storing curling iron on 12/13/2023. Discussed with resident safety precautions and resident deemed unsafe and will only use curling iron while supervised by facility staff. Curling iron to be stored, by the facility, in a location accessible for the resident to use, under supervision. • Residents within the facility have the potential to be affected by this practice. • Facility-wide audit completed of resident's rooms and common areas. No further devices with a heating element were found. • Facility is free of Accidents and Hazards Policy and procedure will be reviewed and revised as necessary by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Education was provided to the clinical staff related to the accidents and hazards by 12/22/2023. • Director of Nursing and/or designee to conduct an audit of common areas and resident rooms for objects containing a heating element weekly x6 weeks. Responsible party: Director of Nursing and/or Designee Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 During an interview on 11/21/23 at 12:59 p.m., the nurse manager LPN-B stated if a resident wanted to curl their own hair, an assessment would need to be completed to ensure it was safe for the resident to use. LPN-B wasn't aware R2 had a curling iron in her room. During an interview on 11/22/23 at 7:49 a.m., NA-A stated she had seen a curling iron plugged into an extension cord and the curling iron was stored in a drawer in the nightstand in R2's room. During an interview on 11/22/23 at 9:12 a.m., the director of nursing (DON) stated if a resident wanted to use a curling iron, occupational therapy would need to do an assessment to make sure the resident was safe to use it. Once the assessment was complete, the interdisciplinary team (IDT) would have a meeting to discuss it. The DON further stated anything with a heating element should be supervised because it could cause a fire or the resident could get burned. During an interview on 11/22/23 at 9:40 a.m., the director of therapy stated R2 had not been assessed for safety regarding the use of a curling iron. A facility policy on accidents dated 11/23, indicated all resident environments will remain as free of accident hazards as is possible and each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: o Identifying hazard(s) and risk(s) o Evaluating and analyzing hazard(s) and risk(s) o Implementing interventions to reduce hazard(s) and risk(s) o Monitoring for effectiveness and modifying	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 interventions when necessary.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure coordination of dialysis care for 1 of 1 resident (R25) who required dialysis (treatment to filter blood when kidneys are no longer able). Findings include: R25's admission Minimum Data Set (MDS) dated 10/13/23, indicated R25 was cognitively intact and had diagnoses of diabetes and kidney failure. Furthermore, R25's MDS indicated R25 required dialysis treatment. R25's provider order dated 9/30/23, directed the morning nurse to ensure dialysis communication form goes with R25 for dialysis treatments every Monday, Wednesday, and Friday. R25's care plan dated 10/20/23, indicated R25 refused scheduled dialysis treatments and a goal of no missed appointments through the next review period. R25's dialysis communication sheets and dialysis run sheets were requested however not received.	F 698	Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The facility will have ongoing communication with the outpatient Dialysis center to provide continuity of care for the resident. • Dialysis Communication Binder was created for resident R25 on 11/22/2023. Licensed nurse to provide the dialysis clinic with Dialysis Communication sheets completed by the facility and the outpatient clinic. Dialysis run progress notes from 09/27/2023 to 11/23/23 were obtained from the dialysis center and uploaded into the resident's electronic health record on 11/23/23. Comprehensive Care Plan was reviewed and revised as necessary • Residents receiving dialysis have the potential to be affected by this practice. • End Stage Renal Disease (ESRD) Policy and procedure will be reviewed and revised as necessary by the Interdisciplinary Team (IDT) and	1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 16 When interviewed on 11/20/23 at 5:08 p.m., R25 stated he had never been sent with any paperwork from the facility when going to dialysis appointments. When interviewed on 11/21/23 at 11:14 a.m., licensed practical nurse (LPN)-A stated when a resident goes to dialysis, a communication sheet was usually sent with them which included a weight and vital signs. LPN-A further stated the paperwork was kept in a book located at the desk. LPN-A verified there were no dialysis communication sheets for R25, and LPN-A had never sent any paperwork with R25 to dialysis appointments. When interviewed on 11/21/23 at 2:31p.m., LPN-B stated residents who receive dialysis are sent with communication sheets. After their appointment, the communication sheet and dialysis run sheet was returned and placed in the resident's binder. LPN-B further stated R25 should have a dialysis binder at the desk. When interviewed on 11/22/23 at 9:23 a.m., the dialysis clinical manager verified R25 received dialysis treatment at their dialysis facility. The clinical manager further stated R25 had never been sent with any communication forms and there had been no communication with the facility. Furthermore, the clinical manager stated there have been times R25 had refused the dialysis treatment without notification from the facility. When interviewed on 11/22/23 at 10:24 a.m., the director of nursing (DON) stated R25 now had a dialysis binder in place, and he had requested	F 698	presented to the QAA/QAPI Committee on 12/21/2023. • Education was provided to clinical staff related to collaboration of care with dialysis centers by 12/22/2023. • Dialysis Communication Binder to be audited by Director of Nursing and/or Designee x3/week x3 weeks then weekly x3 weeks. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. QAA/QAPI Committee to determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible Party: Director of Nursing and/or designee Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 17 R25's dialysis run notes and treatment notes to be sent to the facility. DON further stated staff were expected to have the communication process in place from when R25 had first came to the facility as it was important for R25's health and coordination of care. A long-term care facility and outpatient dialysis services coordination agreement dated 2/27/19, directed both parties shall ensure there was documented evidence of collaboration of care and communication between the long-term care facility and dialysis facility. Furthermore, the contract directed the care facility to keep a copy of the resident's short term and long-term dialysis care plan. A facility policy titled End-Stage Renal Disease, Care of a Resident revised 2010, directed agreements between the facility and dialysis facility include all aspects of how the resident care will be managed including how information will be exchanged between facilities.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 18 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to re-evaluate the continued use of an as needed (PRN) antianxiety medication	F 758	The resident has the right to be free of unnecessary drugs. • R13's PRN Ativan rationale was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 19 every 14 days as required for 1 of 1 residents (R13) reviewed for PRN antianxiety medication. Findings include: R13's quarterly Minimum Data Set (MDS) dated 9/6/23, identified R13 had severely impaired cognition. R13 was assessed to have depression. R13 had behaviors of refusing cares 1 - 3 times a week. R13 had diagnoses of depression, acute kidney failure, and atrial fibrillation. R13 received an antianxiety on a routine and PRN basis. R13's Medication Administration Records (MAR) for October 2023, and November 2023, identified R13 had an order for Lorazepam (an antianxiety)1 milligrams (mg) by mouth every four hours as needed for anxiety/restlessness. The order originated on 10/16/23, and there was no end date indicated on the MAR. R13 received the PRN medication 10 times in October and 15 times in November. R13's completed pharmacy Consultation Report with recommendation dated 10/20/23, noted R13's medication had been reviewed by the CP and listed, "CMS allows 14 days for PRN anxiolytic's unless the physician provides a longer end date and rational for use. PLEASE PROVIDE A STOP DATE FOR THIS MEDICATION. IT CAN BE EXTENDED OR DECREASED AT ANY TIME. THE OTHER OPTION IS TO WRITE AN ORDER EVERY 14 DAYS." The pharmacy consultant report was unsigned. R13's completed pharmacy Consultation Report with recommendation dated 11/14/23, noted	F 758	provided by the ARNP on 11/24/23. • Residents receiving psychotropic medication have the potential to be affected. • The Consultant Pharmacist, in collaboration with the Prescriber and the Nursing Department, will ensure the resident is free from unnecessary drugs in their medication regimen. • Unnecessary Medication Policy and procedure will be reviewed by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Education was provided to licensed nurses on Psychotropic medications and PRN usage duration by 12/22/2023. • All of October and November's Pharmacy Recommendations were completed on 11/24/23 with the ARNP. December's Pharmacy Recommendations were completed on 12/11/2023. • Director of Nursing and/or designee will audit all new PRN psychotropic medications for an initial 14 day stop date and/or rationale for extension x3/week x3 weeks then weekly x3 weeks. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. The QAA/QAPI Committee will determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible Party: Director of Nursing and/or designee Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 20 R13's medication had been reviewed by the CP and listed, "CMS allows 14 days for PRN anxiolytic's unless the physician provides a longer end date and rational for use. Please provide an end date for PRN Lorazepam : 3 months_____ months_____ 12 months_____."The pharmacy consult report was unsigned by the physician. Interview on 11/21/23 at 2:00 p.m., the director of nursing (DON) indicated he did not know where the October and November pharmacy recommendations were, or if the recommendations were followed up on. Telephone interview on 11/22/23 at 11:38 a.m., the consultant pharmacist indicated he was there in October and November, and noticed that some of the Octobers recommendations were not completed and made repeat recommendations in November.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		1/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper sanitization of dishware used for meal preparation and resident service when 1 of 1 high-temperature commercial dishwashers was identified as not reaching adequate wash and rinse temperatures. In addition, the facility failed to store dishware in a manner preventing contamination. Further, the facility failed to ensure the ice dispensing machine was clean and free of excess mineral build up or cleaned on a regular schedule. This had potential to affect all 36 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen and/or ice from the dining room ice machine. Dishwashing Machine During observation and interview on 11/20/23 at 12:38 p.m., the label on the side of the Hobart AM-14 dishwasher indicated dish sanitization required a wash temperature of 150°F for a minimum of 40 seconds and rinse temperature of 180°F for a minimum of nine seconds. Dietary aide (DA)-A stated the dishwasher used hot water to sanitize and confirmed the temperatures needed to reach 150 degrees Fahrenheit (°F) during the wash cycle and 180°F during the rinse cycle. DA-A placed a tray containing three large pans and several small lids into the dishwasher, closed the door, and started the unit. The	F 812	Dishwashing Machine Corrective Action Measures 1. Kitchen Staff was immediately educated on proper dish machine use, temperature monitoring, and reporting of temperature or mechanical issues on Tuesday, November 21, 2023. Kitchen Staff not in the building on 11/21/23 were educated by FSD/CDM at the beginning of their next shift. Signs posted in the dish area. Dish machine usage ceased until Ecolab came to service machine on Tuesday, November 21, 2023, and temperatures were verified to be within required ranges. 2. Mandatory Kitchen Staff in-service on proper usage of dish machine, temperature monitoring, and reporting of temperature or mechanical issues. Date: January 9, 2024, 2:30pm 3. Kitchen Orientation of new staff will be completed by FSD/CDM and RD rather than the cook or dietary aid. Dish Machine use is covered in the Kitchen Orientation. Date: Immediately. 4. Hobart serviced dish machine. Date: Friday, November 24, 2023. 5. Waterproof Thermometer is being used to verify dish machine water temperatures on a weekly basis by the FSD/CDM. Date: Immediately. Dishwashing Machine Corrective Action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 22 temperature began at 155°F, fell during the wash cycle to 147°F, and rose to 186°F at the start of the rinse cycle. The dishwasher door was opened immediately upon reaching 186°F prior to the nine second requirement. At 12:42 p.m., DA-A placed three trays and nine lids on the dish rack, placed the rack into the dishwasher, and started the unit. The wash cycle temperature started at 151°F and steadily decreased during the cycle until it reached 146 °F. The rinse temperature reached 189°F. DA-A confirmed the temperatures did not stay elevated as required and was not sure why. The door was opened, and the dishes were placed on the storage cart. At 12:55 p.m., DA-A placed one large pan into the dishwasher. The wash cycle started at 157°F and decreased to 149°F, and the rinse cycle reached 180°F, however the dishwasher was opened prior to the end of the 9 second minimum. At 12:57 p.m., DA-A placed a tray containing three cups, four bowls, three small metal pans, two plastic covers, and several miscellaneous cooking utensils into the dishwasher and started the unit. The wash cycle started at 152 °F and steadily dropped to 147°F during the cycle. At 12:59 p.m., DA-A stated any of the staff could check the dishwasher temperatures and document them on the log, and it was done randomly. They stated the dishes were clean when the pressure gauge dropped, and they opened the door after they didn't heard noise for a while. At 1:02 p.m., a tray with one large pan and four	F 812	Monitoring 1. FSD/CDM will review monthly reports from Ecolab and take necessary corrective action. Date: Immediately/Monthly. 2. FSD/CDM will verify dish machine temperatures and record weekly using the waterproof thermometer and will confirm recorded temperatures are within acceptable parameters. Date: Audit 3xweek for 3 weeks and one time a week for 3 weeks. Date Completed: January 29th, 2024. Fans in the dish washing room Corrective Action 1. Fans were immediately cleaned. Date: Tuesday, November 21, 2023. 2. Fans will be cleaned on a weekly basis. This task was added to the cleaning checklist for AM Dietary Aid. The AM cook will verify the fans are clean daily. This task was added to the AM cook cleaning checklist. Date: Immediately/Weekly/Daily. 3. Kitchen Staff in-service on cleaning the fans. Date: January 9, 2023. Fans in the dish washing room Corrective Action Monitoring 1. FSD/CDM will monitor completion of cleaning checklists on a weekly basis and if fans are not clean, will follow up with and re-educate the responsible party. Audits will be 3xweek for 3 weeks and 1xweek for 3 weeks. Completion Date: January 29th, 2024. Ice Machine Cleaning Corrective Action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 plate holders was placed into the dishwasher and the unit was started. Both wash and rinse cycle temperatures remained within acceptable limits. During observation on 11/21/23 between 9:13 a.m. and 9:16 a.m., the dishwasher was observed to reach wash and rinse temperatures of greater than 150°F and 180°F during three cycles. During interview and observation on 11/21/23 at 12:20 p.m., DA-C placed three bowls, two pitchers, one graduate, two plastic containers, and two juice cups in the dish rack and slid the rack into the dishwasher. The temperature gauge indicated it was in the "fill" cycle. At 12:24 p.m., DA-C started the washer and observed the wash temperature of 139°F which fell steadily to 131°F. The rinse cycle reached 145°F before the dishwasher stopped. DA-C opened the door, removed the dishes, and prepared another tray containing food processor parts. DA-C started the load at 12:26, and the wash and rinse temperatures reached 138°F and 156°F. DA-C stated those were normal temperatures for the dishwasher, and they had always been that way. DA-C stated they knew the dishes were clean because they were "really hot", and staff could not touch them when they first came out of the dishwasher. DA-C began another load of dishware which started at 140°F, dropped to 136°F during the cycle, reached 185°F during the rinse cycle, but dropped to 137°F after approximately five seconds. During observation and interview on 11/21/23 at 12:30 p.m., dietary director (DD) stated the dishwasher maintenance company was at the facility recently and the dishwasher was functioning properly. He stated there was a	F 812	1. Ice Machine was immediately cleaned. Date: Wednesday, November 22, 2023. 2. Kitchen Staff in-service on cleaning of the ice machine. Date: January 9, 2024. 3. Ice Machine will be delimed and deep cleaned on a weekly basis. This task was added to the cleaning checklist for the PM Cook. Date: Immediately/Weekly. 4. Ice Machine will receive general cleaning daily by 10:30am-7pm Dietary Aid. Date: Immediately/Daily. Ice Machine Cleaning Corrective Action Monitoring 1. FSD/CDM will monitor completion of cleaning checklists on a weekly basis and if ice machine is not clean, will follow up with and re-educate the responsible party. Audits will be 3xweek for 3 weeks and 1xweek for 3 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 24 booster heater on the unit and sometimes the temperatures fluctuated, but it should be run at 150°F for the wash cycle and 180°F for the rinse cycle to prevent foodborne illness. At 12:32 p.m., DD observed a cycle of dishware which started at 143°F and dropped to 139°F during the wash cycle. He stated the load was not clean and needed to be rewashed. At 12:34 the load was started again where temperatures started at 145°F and dropped to 140°F during the wash cycle. DD stated staff checked the dishwasher temperatures at the start, middle, and end of doing the dishes, and was not sure why it was not getting up to temperature, but identified dishes would need to be sanitized manually using the three compartment sink until it could be fixed. During interview on 11/21/23 at 12:43 p.m., administrator stated the wash cycle should reach 145°F and the rinse cycle should reach 180°F, and staff needed to make sure it hit 180°F to ensure the dishes were sanitized. The Hobart Model AM14 Instructions dated 1/1989, indicated the minimum water temperature required for hot water dish sanitation was 150°F for a recommended 40 seconds during the wash cycle and 180°F during the rinse cycle for a recommended 18 seconds. The facility Sanitization policy dated 10/2008, indicated dishwashing machines must be operated using a wash temperature of 150°F for at least 45 seconds and a rinse temperature of 180°F for at least 12 seconds. The Dishwashing Machine Use policy dated 3/2010, indicated the operator will check temperatures using the machine gauge with each	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25	F 812		

dishwashing machine cycle and monitor the gauge frequently during the machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately.

Fans

During observation of the dish washing room on 11/20/23 at 11:57 a.m., a large fan was attached to the wall near the ceiling on the "dirty" side where the soiled dishes came in and another smaller fan was attached to the wall on the "clean" side where the clean dishes were stored and put away. Both fans were turned on, oscillating, and moving air about the room, and both were covered in thick, brown dusty substance. The fan on the "clean" side was located approximately three feet from a shelf containing clean cups just above the counter where clean dishes were placed when removed from the dishwasher.

During observation on 11/20/23, at 12:50 p.m. the smaller fan was blowing on two trays containing 16 clean cups and a tray of 10 clean coffee cups located on the shelf above the clean dish counter.

During interview on 11/20/23 at 12:59 p.m. DA-A stated the fans were usually on because the room got hot.

During observation on 11/21/23 at 12:12 p.m. both fans were oscillating in the dish washing and storage area, the smaller of which was blowing on the clean dish counter which contained metal serving pans and cooking utensils just out of the dishwasher. The shelf above the counter contained 19 clean plastic cups, and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26 three-tiered cart which contained a baking sheet, and two clean plates was against the wall, also in the fan's range. At 12:20 p.m. DA-C placed the pans and utensils on a wire dish storage rack within the room and added three cups to the others on the shelf. During interview on 11/21/23 at 12:30 p.m. DD confirmed the fans were soiled and stated they needed to be cleaned because they did not want the dust and particles to get on the dishware and have residents eat off them. During interview on 11/21/23 at 12:43 p.m. administrator stated the fans should be cleaned for sanitation purposes and needed to be added to the dietary staff's cleaning processes. The Sanitization policy dated 10/2008, indicated clean equipment and utensils will be stored in a clean, dry locations in a way that protects them from splashes, dust, or other contamination. Ice Machine During observation on 11/22/23 at 9:24 a.m., the facility ice machine in the resident dining room was located on top of a metal table. The surfaces of the table, front of the ice machine, the dispenser chute, and the drip dray were covered in a white, speckled, crusty, residue. The plastic exterior chute from where the ice was dispensed and the area of attachment to the body of the machine also contained various areas of a black substance, with the one closest to where a cup would be placed running across the bottom of the back of chute and up approximately ¼ inch.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 27 During interview on 11/22/23 at 9:52 a.m., dietary aide DA-B stated they did not know who cleaned the counter and ice machine in the dining room. During interview on 11/22/23 at 9:53 a.m., housekeeper (HSK)-A stated they cleaned the dining room, but the kitchen staff cleaned the ice machine. During interview on 11/22/23 at 9:55 a.m., DA-A stated was not sure who cleaned that area, but thought dietary staff cleaned the counter and maintenance cleaned the ice machine. During interview on 11/22/23 at 9:57 a.m., director of nursing (DON) observed the white and brown substances and stated it needed to be de-limed and cleaned. DON was unsure who was responsible for cleaning. During interview on 11/22/23 at 10:01 a.m., administrator observed the ice machine and identified the condition as a "concern". The administrator stated maintenance did the internal cleaning quarterly and the dietary staff should be cleaning the external parts. Further, stated the machine was the main source of ice and was used for passing water to the residents, and it needed to be cleaned to prevent people from getting ill. During interview on 11/22/23 at 10:19 a.m., dietary director stated they cleaned the outside of the ice machine but did not remember how to take the plastic ice chute cover off, so maintenance helped, but it was important to keep it clean to ensure people did not get sick. The Sanitization policy dated 10/2008, indicated	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 28 ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer's instructions and facility policy. The Nugget Ice Machines Installation, Operation, and Maintenance Manual dated 12/2017, indicated the machine needed to be cleaned and sanitized every six months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment. If required, an extremely dirty ice machine may be taken apart for cleaning and sanitizing. In addition, the manual recommended weekly removal of the grill from scrap ice tray and weekly wiping of splash panel, scrap ice tray and grill with sanitizer and water solution.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed for 3 of 3 residents (R23, R25, R24) observed during wound cares. Furthermore, the facility failed to ensure hand hygiene was completed for 1 of 1 residents (R23) reviewed for toileting. Findings include: R23 R23's quarterly Minimum Data Set (MDS) dated 10/13/23, indicated R23 was cognitively intact and had diagnoses of chronic venous insufficiency (poor blood flow) and bilateral lower extremity vascular wounds. Furthermore, R23's MDS indicated R23 required assist of one for toileting. An observation on 11/21/23 at 7:10 a.m., licensed practical nurse (LPN)-A entered R23's room without performing hand hygiene. R23 requested to use the bed pan. Without hand hygiene, LPN-A donned gloves and obtained R23's bedpan from the bathroom. LPN-A assisted R23 to turn in bed and placed the bedpan. LPN-A then removed gloves and without performing hand hygiene left R23's room and walked down	F 880	It is the practice of the facility to practice appropriate and timely hand hygiene during resident cares. • All residents residing in the facility have the potential to be affected by this practice. • Hand Hygiene Policy and procedure will be reviewed and revised as necessary by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Education provided to clinical staff and practitioners on moments of hand hygiene by 12/22/2023. • Hand hygiene audits to be completed by Director of Nursing, Infection Preventionist and/or designee x5/week x3 weeks then x3 week x3 month. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. QAA/QAPI Committee to determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible party: Director of Nursing and/or Infection Preventionist. Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 hall to obtain washcloths. At 7:15 a.m., LPN-A entered room without performing hand hygiene and donned gloves. LPN-A assisted R23 with turning and removed the bedpan now filled with urine. The bedpan was set on the end of R23's bed while LPN-A cleaned R23 and assisted back on her back. LPN-A then removed gloves and without hand hygiene donned new gloves and picked up the bedpan and emptied the urine in the bathroom. LPN-A then removed gloves and washed hands. LPN-A then left room to obtain a clean draw sheet as R23's had gotten soiled when the bedpan was used. With new drawsheet, LPN-A returned to R23's room and assisted R23 in turning so clean draw sheet could be placed. The soiled drawsheet was placed at the end of R23's bed. Without performing hand hygiene or exchanging gloves, LPN-A adjusted R23's pillows behind her and the pillows under R23's legs. LPN-A then removed the soiled sheet and placed in a bag. LPN-A removed gloves and without performing hand hygiene donned new gloves. LPN-A then gave R23 a clean wet and dry washcloth to wash her face and eyes. LPN-A then removed gloves and performed hand hygiene before leaving the room to look for assistance to boost R23 up in bed. When interviewed on 11/21/23 at 7:35 a.m., LPN-A stated hand hygiene was needed when moving from dirty to clean and between glove changes. LPN-A verified she had not completed hand hygiene in between glove changes when R23 was assisted with the bedpan and handled soiled linen. An observation on 11/21/23 at 8:26 a.m., LPN-B and nurse practitioner (NP)-A entered R23's room to provide wound care. NP-A performed hand hygiene and donned new gloves obtained from	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32	F 880		

her scrub pocket. NP-A removed R23's bilateral lower extremity dressings. NP-A removed gloves and without hand hygiene placed donned a new pair of gloves. A bottle of sterile water was obtained and R23's bilateral wounds were cleansed and wiped with gauze. The gauze used to cleanse R23's wounds had some bloody drainage. The dirty gauze was placed in the garbage and NP-A removed gloves and without performing hand hygiene placed new gloves from scrub pocket. NP-A then moistened gauze and placed on R23's left leg wound, placed and dry dressing and wrapped in kerlix dressing. NP-A then moistened another piece of gauze and placed on R23's right leg wound, placed dry gauze and wrapped in kerlix. NP-A then removed gloves performed hand hygiene before leaving R23's room.

R25

R25's admission (MDS) dated 10/3/23, indicated R25 was cognitively intact and had diagnoses of diabetes and kidney failure. Furthermore, R25's MDS indicated R25 had a pressure wound on the left buttock.

An observation on 11/21/23 at 8:00 a.m., LPN-B and NP-A entered R25's room to perform wound care. NP-A performed hand hygiene and donned gloves. R25's brief was pulled back and dressing removed from R25's bottom. NP-A then removed gloves and without hand hygiene donned new gloves that were pulled out of her scrub pocket. NP-A measured R25's wound before cleansing the wound. NP-A then removed gloves and without hand hygiene donned gloves that were pulled from her scrub pocket. R25's wound was covered. NP-A removed gloves and performed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 hand hygiene upon exit of R25's room. When interviewed on 11/22/23 at 8:45 a.m., NP-A stated when performing wound cares dirty areas and clean areas were kept separate and that was why so many extra gloves in her pocket. NP-A was not aware of any need to perform hand hygiene when exchanging gloves or a need to have hand sanitizer on hand when performing dressing changes. NP-A further stated if gloves were torn during care, then hand hygiene would be completed. When interviewed on 11/21/23 at 2:22 p.m., LPN-B verified NP-A had not performed hand hygiene when removing gloves and stated hand hygiene was to be completed after each glove exchange. Furthermore, LPN-B stated this was important part of infection prevention. R24 R24's quarterly MDS dated 11/3/23 indicated R24 was cognitively intact and had diagnoses of Atrial fibrillation (irregular,often rapid heart rate that commonly causes poor blood flow), chronic kidney disease and pressure ulcer of left buttocks, stage 4 (pressure injuries extend to muscle, tendon or bone), and indicated R24 had one stage 4 pressure ulcer that was present on admit. During observation on 11/21/23 at 7:45 a.m., LPN-B and NP-A entered R24's room to perform wound care. NP-A performed hand hygiene and donned gloves. R24's brief was pulled back and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 dressing removed from R24's bottom. NP-A then removed gloves and without hand hygiene donned new gloves that were pulled out of her scrub pocket. NP-A cleansed wound, removed gloves and without hand hygiene donned new gloves from her scrub pocket. and then measured R25's wound. NP-A then removed gloves and without hand hygiene donned gloves that were pulled from her scrub pocket, and covered R24's wound . NP-A removed gloves and performed hand hygiene upon exit of R24's room. When interviewed on 11/22/23 at 10:18 a.m., the director of nursing (DON) expected hand hygiene to be completed after handling dirty linens or toileting and before moving to clean areas. Hand hygiene was also required in between glove exchanges during cares. Furthermore, the DON expected all staff and providers to follow this practice to ensure infection prevention measures were being followed. A facility policy titled Standard Precautions revised 9/2022, directed staff to perform hand hygiene before and after contact with a resident, and after removing gloves.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 35 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 36 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R1, R9, R18, R21, R27) were provided education regarding risks and benefits, offered, and/or received the pneumococcal vaccine in accordance with the Centers for Disease Control (CDC) recommendations. R1's Medical Diagnosis list dated 11/22/23, included lung disease, heart failure, and opioid dependence. The CDC's PneumoRecs VaxAdvisor indicated for patients aged 19-64 who have not received PCV15 or PCV20, with a risk factor of heart and lung disease and had a PCV13, "Give one dose of PCV20 at least 1 year after PCV13." Or "Give one dose of PPSV23 at least 1 year after PCV13." R1's Order Summary Report dated 11/22/23, included May receive Pneumovax if not already received unless contraindicated starting 11/2/23. R1's Immunization Report dated 11/22/23, indicated R1 refused the PPSV23 vaccine. R1's medical record lacked evidence of provision of education regarding risks and benefits.	F 883	It is the practice of the facility to provide education regarding the risks and benefits, offered and/or received the pneumococcal vaccine in accordance with CDC recommendations. • R1, R9, R18, R21, and R27 were offered eligible pneumococcal vaccinations. Documentation of the offering, refusal and/or administration of the vaccine were entered into the electronic health record. • All residents residing in the facility were offered their eligible pneumococcal vaccination(s) based on the CDC or APIC recommendations. All residents are offered the pneumococcal vaccination(s) upon admission to the facility. Supporting documentation will be entered into the electronic health record. • Resident Immunization Practices Policy and procedure will be reviewed and revised as necessary by the Interdisciplinary Team (IDT) and presented to the QAA/QAPI Committee on 12/21/2023. • Education provided to the licensed nurses on offering the Influenza and Pneumococcal vaccines upon admission and as indicated by 12/22/2023. • Infection Preventionist to maintain a log of all new admissions and their	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 37 R9's Medical Diagnosis list dated 11/22/23, included autistic disorder and high blood pressure. The CDC's PneumoRecs VaxAdvisor indicated for patients aged 65+ who have not received PCV15 or PCV20, who have received a PCV13, and do not have any risk factors, "Give one dose of PCV20 or PPSV23 at least one year after PCV13." R9's Order Summary Report dated 11/22/23, included May receive Pneumovax if not already received unless contraindicated starting 8/9/22. R9's Immunization Report dated 11/22/23, lacked evidence of administration or refusal of PCV20 or PPSV23. R9's medical record lacked evidence of administration, refusal, provision of education regarding risks and benefits, and/or medical contraindication for administration of PCV20 or PPSV23. R18's Medical Diagnosis list dated 11/22/23, included lung disease and heart failure, The CDC's PneumoRecs VaxAdvisor indicated for patients aged 65+ who have not received PCV15 or PCV20, who have received a PCV13, and have risk factors of heart and lung disease, and had a PCV13, "Give one dose of PCV20 or PPSV23 at least one year after PCV13." R18's Order Summary Report dated 11/22/23, included May receive Pneumovax if not already received unless contraindicated starting 1/11/23.	F 883	vaccination status. • Director of Nursing to audit log weekly x6 weeks for compliance. Audits will be brought to the QAA/QAPI Committee to identify tracking or trending. QAA/QAPI Committee to determine if continuation past the initial period is recommended. Re-education will be provided to licensed nurses as indicated. Responsible Party: Infection Preventionist/Director of Nursing Date Certain: 01/03/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 38 R18's Immunization Report dated 11/22/23, lacked evidence of administration or refusal of PCV20 or PPSV23. R18's medical record lacked evidence of administration, refusal, provision of education regarding risks and benefits, and/or medical contraindication for administration of PCV20 or PPSV23. R21's Medical Diagnosis list dated 11/22/23, included diabetes and kidney failure. The CDC's PneumoRecs VaxAdvisor indicated for patients aged 65+ who have not received PCV15 or PCV20, who have received a PCV13, and have risk factors of diabetes and kidney failure, and had a PCV13, "Give one dose of PCV20 at least one year after PCV13 or give one dose of PPSV23 at least 8 weeks after PCV13." R21's Order Summary Report dated 11/22/23, included May receive Pneumovax if not already received unless contraindicated starting 9/8/23. R21's Immunization Report dated 11/22/23, lacked evidence of administration or refusal of PCV20 or PPSV23. R21's medical record lacked evidence of administration, refusal, provision of education regarding risks and benefits, and/or medical contraindication for administration of PCV20 or PPSV23. R27's Medical Diagnosis list dated 11/22/23,	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 39 included epilepsy, diabetes, alcoholism, and nicotine dependence. The CDC's PneumoRecs VaxAdvisor indicated for patients aged 65+ who have not received PCV15 or PCV20, and have not received a PPSV23 or a PCV13, "Give one dose of PCV15 or PCV20." R27's Order Summary Report dated 11/22/23, included May receive Pneumovax if not already received unless contraindicated starting 11/6/23. R27's Immunization Report dated 11/22/23, lacked evidence of administration or refusal of PCV15 or PCV20. R27's medical record lacked evidence of administration, refusal, provision of education regarding risks and benefits, and/or medical contraindication for administration of PCV15 or PCV20. During interview on 11/21/23 at 2:14 p.m., licensed practical nurse (LPN)-A stated staff asked residents upon admission if they had any immunizations in the past, but they did not offer any immunizations themselves. During interview on 11/21/23 at 2:20 p.m.,. infection preventionist (IP) stated they reviewed residents' vaccination status to identify immunization needs and used the CDC PneumoRecs VaxAdvisor telephone application to determine which pneumococcal vaccine, if any, they should offer. They stated they offered the Prevnar 20 at the facility, and they usually provided education, obtained a signed consent or	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 40 declination form which was uploaded into the electronic record, and administered the vaccine within the first couple of days of admission. They stated they were new to the facility and had not yet been able to review all resident charts to determine who needs which vaccines, but it was important to make sure it got done to protect the residents. During interview on 11/21/23 at 2:35 p.m., director of nursing stated they expected all residents to be offered the pneumococcal vaccine to protect them from illness The Infection Prevention and Control Manual Pneumococcal Vaccine Program policy dated 2023, indicated residents will be offered immunization(s) against pneumococcal disease in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations to reduce the incidence of pneumococcal disease and the morbidity and mortality attributed to this infection.	F 883		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fans in the dish sanitization and storage area were maintained in a clean and sanitary manner to prevent dishware contamination. This had potential to affect all 36 residents within the nursing home, staff, and	F 921	Dishwashing Machine Corrective Action Measures 1. Kitchen Staff was immediately educated on proper dish machine use, temperature monitoring, and reporting of temperature or mechanical issues on	1/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 41 visitors who consumed food from the main production kitchen. Findings include: During observation of the dish washing room on 11/20/23 at 11:57 a.m., a large fan was attached to the wall near the ceiling on the "dirty" side where the soiled dishes came in and another smaller fan was attached to the wall on the "clean" side where the clean dishes were stored and put away. Both fans were turned on, oscillating, and moving air about the room, and both were covered in thick, brown dusty substance. The fan on the "clean" side was located approximately three feet from a shelf containing clean cups just above the counter where clean dishes were placed when removed from the dishwasher. During observation on 11/20/23, at 12:50 p.m. the smaller fan was blowing on two trays containing 16 clean cups and a tray of 10 clean coffee cups located on the shelf above the clean dish counter. During interview on 11/20/23 at 12:59 p.m. DA-A stated the fans were usually on because the room got hot. During observation on 11/21/23 at 12:12 p.m. both fans were oscillating in the dish washing and storage area, the smaller of which was blowing on the clean dish counter which contained metal serving pans and cooking utensils just out of the dishwasher. The shelf above the counter contained 19 clean plastic cups, and a three-tiered cart which contained a baking sheet, and two clean plates was against the wall, also in the fan's range. At 12:20 p.m. DA-C placed the	F 921	Tuesday, November 21, 2023. Kitchen Staff not in the building on 11/21/23 were educated by FSD/CDM at the beginning of their next shift. Signs posted in the dish area. Dish machine usage ceased until Ecolab came to service machine on Tuesday, November 21, 2023, and temperatures were verified to be within required ranges. 2. Mandatory Kitchen Staff in-service on proper usage of dish machine, temperature monitoring, and reporting of temperature or mechanical issues. Date: January 9, 2024, 2:30pm 3. Kitchen Orientation of new staff will be completed by FSD/CDM and RD rather than the cook or dietary aid. Dish Machine use is covered in the Kitchen Orientation. Date: Immediately. 4. Hobart serviced dish machine. Date: Friday, November 24, 2023. 5. Waterproof Thermometer is being used to verify dish machine water temperatures on a weekly basis by the FSD/CDM. Date: Immediately. Dishwashing Machine Corrective Action Monitoring 1. FSD/CDM will review monthly reports from Ecolab and take necessary corrective action. Date: Immediately/Monthly. 2. FSD/CDM will verify dish machine temperatures and record weekly using the waterproof thermometer and will confirm recorded temperatures are within acceptable parameters. Date: Audit 3xweek for 3 weeks and one time a week for 3 weeks. Date Completed: January 29th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 42 pans and utensils on a wire dish storage rack within the room and added three cups to the others on the shelf. During interview on 11/21/23 at 12:30 p.m., DD confirmed the fans were soiled and stated they needed to be cleaned because they did not want the dust and particles to get on the dishware and have residents eat off them. During interview on 11/21/23 at 12:43 p.m. administrator stated the fans should be cleaned for sanitation purposes and needed to be added to the dietary staff's cleaning processes. The Sanitization policy dated 10/2008, indicated clean equipment and utensils will be stored in a clean, dry locations in a way that protects them from splashes, dust, or other contamination.	F 921	Fans in the dish washing room Corrective Action 1. Fans were immediately cleaned. Date: Tuesday, November 21, 2023. 2. Fans will be cleaned on a weekly basis. This task was added to the cleaning checklist for AM Dietary Aid. The AM cook will verify the fans are clean daily. This task was added to the AM cook cleaning checklist. Date: Immediately/Weekly/Daily. 3. Kitchen Staff in-service on cleaning the fans. Date: January 9, 2023. Fans in the dish washing room Corrective Action Monitoring 1. FSD/CDM will monitor completion of cleaning checklists on a weekly basis and if fans are not clean, will follow up with and re-educate the responsible party. Audits will be 3xweek for 3 weeks and 1xweek for 3 weeks. Completion Date: January 29th, 2024. Ice Machine Cleaning Corrective Action 1. Ice Machine was immediately cleaned. Date: Wednesday, November 22, 2023. 2. Kitchen Staff in-service on cleaning of the ice machine. Date: January 9, 2024. 3. Ice Machine will be delimed and deep cleaned on a weekly basis. This task was added to the cleaning checklist for the PM Cook. Date: Immediately/Weekly. 4. Ice Machine will receive general cleaning daily by 10:30am-7pm Dietary Aid. Date: Immediately/Daily. Ice Machine Cleaning Corrective Action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 43	F 921	Monitoring 1. FSD/CDM will monitor completion of cleaning checklists on a weekly basis and if ice machine is not clean, will follow up with and re-educate the responsible party. Audits will be 3xweek for 3 weeks and 1xweek for 3 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/21/2023. At the time of this survey, New Brighton Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 57 beds and had a census of 37 at the time of the survey.	K 000		
K 211 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1.This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 10:37 AM, it was revealed by observation that there was a chair in the corridor	K 211	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. K211 – Means of Egress • Stationary chairs have been removed from hallways. • Means of Egress will be added to a weekly maintenance rounding checklist.	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 3 near resident room 105. 2. On 11/21/2023 at 11:05 AM, it was revealed by observation that there were two chairs in the corridor near resident room 202 and 212. An interview with the Administrator verified these deficient findings at the time of discovery.	K 211	• A copy of the checklist will need to be emailed to the Administrator weekly • Maintenance Manager/Technician is responsible. • Date Corrected: January 29th, 2024.	
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, and 7.2.2.5.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/21/2023 at 11:10 AM, it was revealed by observation that there was a floor fan stored at the bottom of the stairwell by the main entrance. An interview with the Administrator verified this deficient finding at the time of discovery.	K 225	K225 – Stairways and Smokeproof Enclosures • Any items stored in the stairwells will be removed. • Stairway storage will be checked weekly by the maintenance manager/technician. • Date Corrected: January 29th, 2024.	1/29/24
K 291 SS=D	Emergency Lighting	K 291		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 4 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been testing emergency lighting. 2. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by observation that the emergency lighting located in the occupational therapy room 112 was not operational when tested. An interview with the Administrator verified these deficient findings at the time of discovery.	K 291	K291 – Emergency Lighting • Check illumination of exit lighting and exit signs has been added to the monthly TELS software system. • The system alerts the Administrator on a weekly basis of incomplete tasks. Administrator will follow up with maintenance manager or technician if notified of incompleteness. • Maintenance Manager/Technician • Date Corrected: January 29th, 2024.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 5 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 10:31 AM, it was revealed by	K 321	K321 – Hazardous Areas – Enclosures • The two small holes in the door for the East utility room will be filled appropriately. • Staff will be educated about propping doors open at the all-staff meetings 1/16 & 1/18/2024. • Doors will be labeled, “Keep Closed.” • The Lower-Level Apartment will be assessed for storage need and the closure will be updated if needed. • Date Corrected: January 29th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 6 observation that there were two small holes in the door for the east utility room. 2. On 11/21/2023 at 10:56 AM, it was revealed by observation that there was paper stuffed in the door strike for the soiled utility room 229 causing the door to not latch. 3. On 11/21/2023 at 11:30 AM, it was revealed by observation that room 2 on the lower level was repurposed as a storage room and the door was not self-closing. An interview with the Administrator verified these deficient findings at the time of discovery.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 7 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/21/2023 at 11:26 AM, it was revealed by observation that the lockout switch installed on the residential stove located in Occupational Therapy room 112 was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Administrator verified this deficient findings at the time of discovery.	K 324	K324 – Cooking Facilities • Have timer installed on lockout switch. • Maintenance Manager/Technician • Date Corrected: January 29th, 2024.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the	K 363		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 8 passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 363	K363 – Corridor – Doors • Staff will be educated on Door propping at the All Staff 1/16 & 1/18/2024. • Door propping with wedge or tissue in door strike have been added to the weekly maintenance rounding checklist. • The Maintenance Manager or Technician are responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 9 1. On 11/21/2023 at 10:29 AM, it was revealed by observation that the south nursing station charting room door was propped open with a rubber wedge. 2. On 11/21/2023 at 10:49 AM, it was revealed by observation the kitchen door was propped open with a rubber wedge. An interview with the Administrator verified these deficient findings at the time of discovery.	K 363	• Date Corrected: January 29th, 2024.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 372	K372 – Building Spaces – Smoke Barriers • The penetrations will be filled by January 29th, 2024, by the maintenance manager/technician.	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 10 On 11/21/2023 at 10:26 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near resident room 105 caused by wires. An interview with the Administrator verified this deficient finding at the time of discovery.	K 372		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a report showing that they had their fire dampers inspected.	K 521	K521 – HVAC • Fire Damper and Smoke Damper Inspection and Testing has been added to the TELS software system for January 2024. • The inspection will be scheduled or completed by January 29th, 2024, by the maintenance manager or technician.	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 11 An interview with the Administrator verified these deficient findings at the time of discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 4.6.1.1 and 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the third shift during the first quarter of 2023. 2. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the facility was not varying the	K 712	K712 - Fire Drills • The fire drill book is being redeveloped to be organized and proactive. • The maintenance manager and technician will be educated on the fire drill book and the need to stagger drill times more drastically than prior. • The fire drills are part of the TELS software system currently. • Date Corrected: January 29th, 2024.	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 12 times that they were conducting the fire drills. The second shift drills were conducted on 03/03/2023 at 03:45 PM, 06/26/2023 at 04:00 PM, and 09/29/2023 04:00 PM. The two third shift drill that were completed were completed on 04/15/2023 at 04:50 AM and 07/21/2023 at 05:04 AM. An interview with the Administrator verified these deficient findings at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.	K 761	K761 – Maintenance, Inspection & Testing Doors • Inspection – Latch and Gap has been scheduled annually in TELS software system for January 2024. • The inspection will be scheduled or completed by January 29th, 2024, by the maintenance manager or technician. • Completion date: January 29th, 2024	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 13 Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that there had been an inspection completed on the fire doors in the facility. An interview with the Administrator verified this deficient finding at the time of discovery.	K 761		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available	K 901	K901 – Building System Categories • The Administrator was not asked for this documentation. The NBCC Administrator and the President of North Cities Health Care, owner and operator of New Brighton Care Center completed a Risk Assessment 1/31/2023. • Completed.	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 14 documentation that at the time of the survey the facility could not provide an NFPA 99 Risk Assessment. An interview with the Administrator verified this deficient finding at the time of discovery.	K 901		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. These deficient findings could have a widespread	K 914	K914 – Electrical Systems – maintenance and testing • The electrical receptacle testing document is being reconfigured and developed with complete details of date and room numbers.	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 15 impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the electrical receptacle testing documentation that was provided at the survey showed that resident rooms 202 and 222 had not been tested, and the page for the 200 wings of the building did not have a date so the surveyor was unable to determine when the inspections happened. An interview with the Administrator verified these deficient findings at the time of discovery.	K 914	• The maintenance manager and technician will be trained in necessary complete documentation. • Date Completed: January 29th, 2024.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel.	K 918		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 16 Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1, 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that weekly inspections were completed on the emergency generator during the week of November 6th 2023, and November 13th 2023, or before March of 2023.	K 918	K918 – Electrical Systems – Essential Electric System Maintenance and Testing • Weekly Generator Inspection has been added to the Weekly Maintenance Rounding Checklist • The monthly generator run – transfer load – inspection is in the TELS software system. • The 4-hour generator test is scheduled on January 24th, 2024. • The report will be filed in the maintenance book for completion. • Date Completed: January 24th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 17 2. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the inspection report for the monthly emergency generator inspection that was completed for January 2023 was not filled out. 3. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the generator has had a four (4) hour load bank test completed within the last 36 months. An interview with the Administrator verified these deficient findings at the time of discovery.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are	K 920		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 18 removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 10:41 AM, it was revealed observation that there was a blue extension cord in resident room 111 that the team from the Minnesota Department of Health (MDH) witnessed being used. 2. On 11/21/2023 at 10:47 AM, it was revealed observation there was a tan extension cord in the CPR board room being used to power computer equipment. An interview with the Administrator verified these deficient findings at the time of discovery.	K 920	K920 – Electrical Equipment • Blue extension cord in room 111 will be evaluated for use. • The tan extension cord in the CPR board will be replaced with an outlet. • The outlet will be planned to be installed or will be complete by January 29th, 2024.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 19 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code,	K 923	K923 – Gas Equipment – Cylinder and Container Storage • The empty and full cylinders will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 20 sections 11.6.2.3, 11.6.5.2 and 11.6.5.3. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 11:23 AM, it was revealed observation that the empty and full oxygen cylinders in the oxygen room were not segregated, and empty cylinders were not marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. 2. On 11/21/2023 at 11:23 AM, it was revealed observation there was one freestanding oxygen cylinder that was not properly chained or supported in a proper cylinder stand or cart. An interview with the Administrator verified these deficient findings at the time of discovery.	K 923	separated in the oxygen room. • Empty cylinders will be marked with a tag stating empty. • Staff will be educated on the importance of oxygen room, the cylinders being chained or supported in the proper cylinder stand at the whole staff meeting in January 2024. • Date Completed: January 29th, 2024.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012	K 926	K926 – Gas Equipment – Qualifications and Training • All current staff of NBCC have been	1/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST** **NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 21 edition), Health Care Facilities Code, section 11.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by available documentation that at the time of the survey the facility could not provide documentation showing that personnel in the facility concerned with the application and maintenance of medical gases and others who handle medical gases are receiving continuing education for the safety guidelines and usage requirements for medical gases and their cylinders. An interview with the Administrator verified this deficient finding at the time of discovery.	K 926	assigned oxygen training in Relias with due date of January 29th, 2024. • Oxygen safety training has been assigned to all nurses and nursing assistants annual training. • Date Completed: January 29th, 2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2023

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: DYZF11

Dear Administrator:

The above facility was surveyed on November 20, 2023 through November 22, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/20/23-11/22/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed during the survey: H54217148C (MN00098224). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper sanitization of dishware used for meal preparation and resident service when 1 of 1 high-temperature commercial dishwashers was identified as not reaching adequate wash and rinse temperatures. In addition, the facility failed to store dishware in a manner preventing contamination. Further, the facility failed to ensure the ice dispensing machine was clean and free of excess mineral build up or cleaned on a regular schedule. This had potential to affect all 36 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen and/or ice from the dining room ice machine. Dishwashing Machine	21015	Corrected	1/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 3 During observation and interview on 11/20/23 at 12:38 p.m., the label on the side of the Hobart AM-14 dishwasher indicated dish sanitization required a wash temperature of 150°F for a minimum of 40 seconds and rinse temperature of 180°F for a minimum of nine seconds. Dietary aide (DA)-A stated the dishwasher used hot water to sanitize and confirmed the temperatures needed to reach 150 degrees Fahrenheit (°F) during the wash cycle and 180°F during the rinse cycle. DA-A placed a tray containing three large pans and several small lids into the dishwasher, closed the door, and started the unit. The temperature began at 155°F, fell during the wash cycle to 147°F, and rose to 186°F at the start of the rinse cycle. The dishwasher door was opened immediately upon reaching 186°F prior to the nine second requirement. At 12:42 p.m., DA-A placed three trays and nine lids on the dish rack, placed the rack into the dishwasher, and started the unit. The wash cycle temperature started at 151°F and steadily decreased during the cycle until it reached 146 °F. The rinse temperature reached 189°F. DA-A confirmed the temperatures did not stay elevated as required and was not sure why. The door was opened, and the dishes were placed on the storage cart. At 12:55 p.m., DA-A placed one large pan into the dishwasher. The wash cycle started at 157°F and decreased to 149°F, and the rinse cycle reached 180°F, however the dishwasher was opened prior to the end of the 9 second minimum. At 12:57 p.m., DA-A placed a tray containing three cups, four bowls, three small metal pans, two plastic covers, and several miscellaneous	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 4 cooking utensils into the dishwasher and started the unit. The wash cycle started at 152 °F and steadily dropped to 147°F during the cycle. At 12:59 p.m., DA-A stated any of the staff could check the dishwasher temperatures and document them on the log, and it was done randomly. They stated the dishes were clean when the pressure gauge dropped, and they opened the door after they didn't heard noise for a while. At 1:02 p.m., a tray with one large pan and four plate holders was placed into the dishwasher and the unit was started. Both wash and rinse cycle temperatures remained within acceptable limits. During observation on 11/21/23 between 9:13 a.m. and 9:16 a.m., the dishwasher was observed to reach wash and rinse temperatures of greater than 150°F and 180°F during three cycles. During interview and observation on 11/21/23 at 12:20 p.m., DA-C placed three bowls, two pitchers, one graduate, two plastic containers, and two juice cups in the dish rack and slid the rack into the dishwasher. The temperature gauge indicated it was in the "fill" cycle. At 12:24 p.m., DA-C started the washer and observed the wash temperature of 139°F which fell steadily to 131°F. The rinse cycle reached 145°F before the dishwasher stopped. DA-C opened the door, removed the dishes, and prepared another tray containing food processor parts. DA-C started the load at 12:26, and the wash and rinse temperatures reached 138°F and 156°F. DA-C stated those were normal temperatures for the dishwasher, and they had always been that way. DA-C stated they knew the dishes were clean because they were "really hot", and staff could not	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 5 touch them when they first came out of the dishwasher. DA-C began another load of dishware which started at 140°F, dropped to 136°F during the cycle, reached 185°F during the rinse cycle, but dropped to 137°F after approximately five seconds. During observation and interview on 11/21/23 at 12:30 p.m., dietary director (DD) stated the dishwasher maintenance company was at the facility recently and the dishwasher was functioning properly. He stated there was a booster heater on the unit and sometimes the temperatures fluctuated, but it should be run at 150°F for the wash cycle and 180°F for the rinse cycle to prevent foodborne illness. At 12:32 p.m., DD observed a cycle of dishware which started at 143°F and dropped to 139°F during the wash cycle. He stated the load was not clean and needed to be rewashed. At 12:34 the load was started again where temperatures started at 145°F and dropped to 140°F during the wash cycle. DD stated staff checked the dishwasher temperatures at the start, middle, and end of doing the dishes, and was not sure why it was not getting up to temperature, but identified dishes would need to be sanitized manually using the three compartment sink until it could be fixed. During interview on 11/21/23 at 12:43 p.m., administrator stated the wash cycle should reach 145°F and the rinse cycle should reach 180°F, and staff needed to make sure it hit 180°F to ensure the dishes were sanitized. The Hobart Model AM14 Instructions dated 1/1989, indicated the minimum water temperature required for hot water dish sanitation was 150°F for a recommended 40 seconds during the wash cycle and 180°F during the rinse cycle for a	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 6 recommended 18 seconds. The facility Sanitization policy dated 10/2008, indicated dishwashing machines must be operated using a wash temperature of 150°F for at least 45 seconds and a rinse temperature of 180°F for at least 12 seconds. The Dishwashing Machine Use policy dated 3/2010, indicated the operator will check temperatures using the machine gauge with each dishwashing machine cycle and monitor the gauge frequently during the machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. Fans During observation of the dish washing room on 11/20/23 at 11:57 a.m., a large fan was attached to the wall near the ceiling on the "dirty" side where the soiled dishes came in and another smaller fan was attached to the wall on the "clean" side where the clean dishes were stored and put away. Both fans were turned on, oscillating, and moving air about the room, and both were covered in thick, brown dusty substance. The fan on the "clean" side was located approximately three feet from a shelf containing clean cups just above the counter where clean dishes were placed when removed from the dishwasher. During observation on 11/20/23, at 12:50 p.m. the smaller fan was blowing on two trays containing 16 clean cups and a tray of 10 clean coffee cups located on the shelf above the clean dish counter. During interview on 11/20/23 at 12:59 p.m. DA-A	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 7 stated the fans were usually on because the room got hot. During observation on 11/21/23 at 12:12 p.m. both fans were oscillating in the dish washing and storage area, the smaller of which was blowing on the clean dish counter which contained metal serving pans and cooking utensils just out of the dishwasher. The shelf above the counter contained 19 clean plastic cups, and a three-tiered cart which contained a baking sheet, and two clean plates was against the wall, also in the fan's range. At 12:20 p.m. DA-C placed the pans and utensils on a wire dish storage rack within the room and added three cups to the others on the shelf. During interview on 11/21/23 at 12:30 p.m. DD confirmed the fans were soiled and stated they needed to be cleaned because they did not want the dust and particles to get on the dishware and have residents eat off them. During interview on 11/21/23 at 12:43 p.m. administrator stated the fans should be cleaned for sanitation purposes and needed to be added to the dietary staff's cleaning processes. The Sanitization policy dated 10/2008, indicated clean equipment and utensils will be stored in a clean, dry locations in a way that protects them from splashes, dust, or other contamination. Ice Machine During observation on 11/22/23 at 9:24 a.m., the facility ice machine in the resident dining room was located on top of a metal table. The surfaces of the table, front of the ice machine, the	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 8 dispenser chute, and the drip dray were covered in a white, speckled, crusty, residue. The plastic exterior chute from where the ice was dispensed and the area of attachment to the body of the machine also contained various areas of a black substance, with the one closest to where a cup would be placed running across the bottom of the back of chute and up approximately ¼ inch. During interview on 11/22/23 at 9:52 a.m., dietary aide DA-B stated they did not know who cleaned the counter and ice machine in the dining room. During interview on 11/22/23 at 9:53 a.m., housekeeper (HSK)-A stated they cleaned the dining room, but the kitchen staff cleaned the ice machine. During interview on 11/22/23 at 9:55 a.m., DA-A stated was not sure who cleaned that area, but thought dietary staff cleaned the counter and maintenance cleaned the ice machine. During interview on 11/22/23 at 9:57 a.m., director of nursing (DON) observed the white and brown substances and stated it needed to be de-limed and cleaned. DON was unsure who was responsible for cleaning. During interview on 11/22/23 at 10:01 a.m., administrator observed the ice machine and identified the condition as a "concern". The administrator stated maintenance did the internal cleaning quarterly and the dietary staff should be cleaning the external parts. Further, stated the machine was the main source of ice and was used for passing water to the residents, and it needed to be cleaned to prevent people from getting ill.	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 9 During interview on 11/22/23 at 10:19 a.m., dietary director stated they cleaned the outside of the ice machine but did not remember how to take the plastic ice chute cover off, so maintenance helped, but it was important to keep it clean to ensure people did not get sick. The Sanitization policy dated 10/2008, indicated ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer's instructions and facility policy. The Nugget Ice Machines Installation, Operation, and Maintenance Manual dated 12/2017, indicated the machine needed to be cleaned and sanitized every six months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment. If required, an extremely dirty ice machine may be taken apart for cleaning and sanitizing. In addition, the manual recommended weekly removal of the grill from scrap ice tray and weekly wiping of splash panel, scrap ice tray and grill with sanitizer and water solution. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop, review, and/or revise policies and procedures to ensure dishwasher temperatures were monitored per manufacturer's guidelines; and could educate all appropriate staff on the policies and procedures; and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed for 3 of 3 residents (R23, R25, R24) observed during wound cares. Furthermore, the facility failed to ensure hand hygiene was completed for 1 of 1 residents (R23) reviewed for toileting. Findings include: R23 R23's quarterly Minimum Data Set (MDS) dated 10/13/23, indicated R23 was cognitively intact and had diagnoses of chronic venous insufficiency (poor blood flow) and bilateral lower extremity vascular wounds. Furthermore, R23's MDS indicated R23 required assist of one for toileting. An observation on 11/21/23 at 7:10 a.m., licensed practical nurse (LPN)-A entered R23's room without performing hand hygiene. R23 requested to use the bed pan. Without hand hygiene, LPN-A donned gloves and obtained R23's bedpan from the bathroom. LPN-A assisted R23 to turn in bed and placed the bedpan. LPN-A then removed gloves and without performing hand hygiene left R23's room and walked down	21375	Corrected	1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 11 hall to obtain washcloths. At 7:15 a.m., LPN-A entered room without performing hand hygiene and donned gloves. LPN-A assisted R23 with turning and removed the bedpan now filled with urine. The bedpan was set on the end of R23's bed while LPN-A cleaned R23 and assisted back on her back. LPN-A then removed gloves and without hand hygiene donned new gloves and picked up the bedpan and emptied the urine in the bathroom. LPN-A then removed gloves and washed hands. LPN-A then left room to obtain a clean draw sheet as R23's had gotten soiled when the bedpan was used. With new drawsheet, LPN-A returned to R23's room and assisted R23 in turning so clean draw sheet could be placed. The soiled drawsheet was placed at the end of R23's bed. Without performing hand hygiene or exchanging gloves, LPN-A adjusted R23's pillows behind her and the pillows under R23's legs. LPN-A then removed the soiled sheet and placed in a bag. LPN-A removed gloves and without performing hand hygiene donned new gloves. LPN-A then gave R23 a clean wet and dry washcloth to wash her face and eyes. LPN-A then removed gloves and performed hand hygiene before leaving the room to look for assistance to boost R23 up in bed. When interviewed on 11/21/23 at 7:35 a.m., LPN-A stated hand hygiene was needed when moving from dirty to clean and between glove changes. LPN-A verified she had not completed hand hygiene in between glove changes when R23 was assisted with the bedpan and handled soiled linen. An observation on 11/21/23 at 8:26 a.m., LPN-B and nurse practitioner (NP)-A entered R23's room to provide wound care. NP-A performed hand hygiene and donned new gloves obtained from her scrub pocket. NP-A removed R23's bilateral	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 12 lower extremity dressings. NP-A removed gloves and without hand hygiene placed donned a new pair of gloves. A bottle of sterile water was obtained and R23's bilateral wounds were cleansed and wiped with gauze. The gauze used to cleanse R23's wounds had some bloody drainage. The dirty gauze was placed in the garbage and NP-A removed gloves and without performing hand hygiene placed new gloves from scrub pocket. NP-A then moistened gauze and placed on R23's left leg wound, placed and dry dressing and wrapped in kerlix dressing. NP-A then moistened another piece of gauze and placed on R23's right leg wound, placed dry gauze and wrapped in kerlix. NP-A then removed gloves performed hand hygiene before leaving R23's room. R25 R25's admission (MDS) dated 10/3/23, indicated R25 was cognitively intact and had diagnoses of diabetes and kidney failure. Furthermore, R25's MDS indicated R25 had a pressure wound on the left buttock. An observation on 11/21/23 at 8:00 a.m., LPN-B and NP-A entered R25's room to perform wound care. NP-A performed hand hygiene and donned gloves. R25's brief was pulled back and dressing removed from R25's bottom. NP-A then removed gloves and without hand hygiene donned new gloves that were pulled out of her scrub pocket. NP-A measured R25's wound before cleansing the wound. NP-A then removed gloves and without hand hygiene donned gloves that were pulled from her scrub pocket. R25's wound was covered. NP-A removed gloves and performed hand hygiene upon exit of R25's room.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 13 When interviewed on 11/22/23 at 8:45 a.m., NP-A stated when performing wound cares dirty areas and clean areas were kept separate and that was why so many extra gloves in her pocket. NP-A was not aware of any need to perform hand hygiene when exchanging gloves or a need to have hand sanitizer on hand when performing dressing changes. NP-A further stated if gloves were torn during care, then hand hygiene would be completed. When interviewed on 11/21/23 at 2:22 p.m., LPN-B verified NP-A had not performed hand hygiene when removing gloves and stated hand hygiene was to be completed after each glove exchange. Furthermore, LPN-B stated this was important part of infection prevention. R24 R24's quarterly MDS dated 11/3/23 indicated R24 was cognitively intact and had diagnoses of Atrial fibrillation (irregular,often rapid heart rate that commonly causes poor blood flow), chronic kidney disease and pressure ulcer of left buttocks, stage 4 (pressure injuries extend to muscle, tendon or bone), and indicated R24 had one stage 4 pressure ulcer that was present on admit. During observation on 11/21/23 at 7:45 a.m., LPN-B and NP-A entered R24's room to perform wound care. NP-A performed hand hygiene and donned gloves. R24's brief was pulled back and dressing removed from R24's bottom. NP-A then removed gloves and without hand hygiene donned new gloves that were pulled out of her scrub pocket. NP-A cleansed wound, removed gloves and without hand hygiene donned new gloves from her scrub pocket. and then	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 14 measured R25's wound. NP-A then removed gloves and without hand hygiene donned gloves that were pulled from her scrub pocket, and covered R24's wound . NP-A removed gloves and performed hand hygiene upon exit of R24's room. When interviewed on 11/22/23 at 10:18 a.m., the director of nursing (DON) expected hand hygiene to be completed after handling dirty linens or toileting and before moving to clean areas. Hand hygiene was also required in between glove exchanges during cares. Furthermore, the DON expected all staff and providers to follow this practice to ensure infection prevention measures were being followed. A facility policy titled Standard Precautions revised 9/2022, directed staff to perform hand hygiene before and after contact with a resident, and after removing gloves. SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff and perform audits to ensure infection hand hygiene and infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines	21426		1/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 15 issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual tuberculosis (TB) testing [Tuberculin skin testing (TST), chest x-ray, or TB blood test] was completed according to the Centers for Disease Control & Prevention (CDC) guidelines, and failed to provide annual TB education for 5 of 5 staff (EE-A, EE-B, RN-C, DA-B, M-A) reviewed for TB education, screening, and testing. This had the potential to affect all residents, staff, and visitors in the facility. Findings include: An untitled document dated 11/12/23, listed the following staff and corresponding hire dates: Employee (EE)-A - 8/30/23 EE-B - 8/15/23	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 16 Registered nurse (RN)-C - 7/19/23 Dietary aide (DA)-B - 10/30/23 Maintenance staff (M)-A - 11/13/23 EE-A's Baseline TB Screening Tool for Health Care Workers (HCW) dated 8/30/23, indicated EE-E received the first step of a two-step TST on 8/30/23, and lacked evidence of a second TST, chest x-ray, or TB blood test. EE-B's Baseline TB Screening Tool for Health Care Workers (HCW) dated 8/16/23, indicated EE-E received the first step of a two-step TST on 8/30/23, and lacked evidence of a second TST, chest x-ray, or TB blood test. RN-C's Baseline TB Screening Tool for Health Care Workers (HCW) (undated) indicated RN-C received the first step of a two-step TST on 7/20/23, and lacked evidence of a second TST, chest x-ray, or TB blood test. DA-B's Baseline TB Screening Tool for Health Care Workers (HCW) dated 10/30/23, indicated DA-B received the first step of a two-step TST on 10/30/23, and lacked evidence of a second TST, chest x-ray, or TB blood test. M-A's Baseline TB Screening Tool for Health Care Workers (HCW) dated 11/13/23, indicated M-A received the first step of a two-step TST on 11/13/23, however lacked results of the TST, chest x-ray, or TB blood test. The employee files for EE-A, EE-B. RN-C, DA-A, and M-A lacked evidence of initial and/or annual TB education. During interview on 11/21/23 at 2:20 p.m. infection preventionist (IP) stated they gave and	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 17 read TSTs to newly hired staff on orientation day, read the test after 48-72 hours, and gave another test 10 days afterward to ensure they did not have an outbreak and to keep residents and staff safe. They stated all documentation went to the human resources department to be added to their employee file. During interview on 11/22/23 at 8:29 a.m. director of nursing stated TB education was not scheduled annually and their expectation was they would follow state requirements, including training, and testing to keep residents safe. The Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH completed 11/30/23, indicated baseline TB screening of all healthcare personnel and employees was performed at the time of hire, and identified the infection preventionist was responsible for maintaining TB screening records which were stored in employee files. The Worksheet also indicated TB training was not performed annually. The Tuberculosis, Employee Screening For policy dated 3,2021, indicated each newly hired employee is screened for latent and active TB after an employment offer has been made but prior to the employee's duty assignment. Screening includes a TST or TB blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and infection preventionist could review and revise policies and procedures for proper monitoring of TB screenings for history, risk factors, symptoms, and TB testing according to the CDC guidelines. The DON or designee, along with the infection preventionist, could audit TB screenings for	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 18 history, risk factors, symptoms, and TB testing on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21426		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2023

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: November 22, 2023

Dear Administrator:

On November 22, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 22, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 22, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2023

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: DYZF11

Dear Administrator:

The above facility was surveyed on November 20, 2023 through November 22, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us